MONTANA CONSUMER'S GUIDE TO MEDICARE SUPPLEMENT INSURANCE

COVERAGES

BENEFIT PLANS

COMPARISONS

John Morrison - State Auditor - Insurance Commissioner

MONTANA STATE AUDITOR
JOHN MORRISON

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

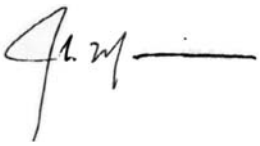
Dear Montana Consumer,

I am pleased to provide you with a copy of the Montana Buyer's Guide to Medicare Supplement Insurance. This guide includes tips on choosing a Medicare supplement, the current coverages provided by Medicare and a chart comparing many of the Medicare supplement policies sold in Montana.

Federal and state regulations require insurance companies to provide Medicare supplement policies that are limited to no more than 12 standard benefit plans. Each of the 12 plans must cover specific expenses. Policy "A" is the most basic and "J" is the most comprehensive. Each company's policies are alike. This guide will make it easier for you to compare plans and premiums.

As you use this guide, please keep in mind that it is just that — a guide — to assist you with your purchasing decision. Shop carefully, take your time and contact our office if you have questions. Our Policyholder Services Division has knowledgeable staff who are dedicated to assisting you with a wide range of insurance questions or problems. Our toll-free number is 1-800-332-6148. Helena residents may reach us at 444-2040.

Sincerely,



State Auditor and
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INTRODUCTION

The **Montana Buyer's Guide to Medicare Supplement Insurance** is a joint effort of the Montana Insurance Department and the State Health Insurance Assistance Program (SHIP) to assist seniors in understanding Medicare and Medicare supplement insurance.

WHAT IS MEDICARE?

Medicare is the federal health insurance program for individuals 65 years of age or older, people of any age with permanent kidney failure and some disabled individuals under age 65.

WILL MEDICARE COVER ME IF I WORK AFTER AGE 65?

If your employer has more than 20 employees and provides health insurance for the employees, your group insurance may be your primary coverage until you leave your job.

WHAT ARE THE "GAPS"?

1. Part A and B deductibles
2. Copayments
3. Charges

WHAT IS PART A?

Part A of Medicare primarily is coverage for inpatient hospitalization. For a more in-depth description please see page 6.

WHAT IS PART B?

Part B of Medicare is called Medical Insurance and covers outpatient services. For a more in-depth description please see page 7.

WHAT IS A BENEFIT PERIOD?

A benefit period begins on the first day of a Medicare-covered inpatient stay. It ends when you have been out of the hospital or skilled nursing facility for 60 consecutive days. A new benefit period begins and the beneficiary must pay a new inpatient hospital deductible. There may be as many as five benefit periods in a calendar year.

WILL MEDICARE COVER ALL MEDICAL EXPENSES?

No. Medicare only covers a portion of health care costs. A Medicare supplement helps with expenses not fully paid by Medicare.

DO SUPPLEMENTS COVER ALL CHARGES MEDICARE DOESN'T?

No. Supplements will not cover expenses if Medicare doesn't pay a portion of the bill, with some exceptions. See the chart on page 11 under Plans F, G, I and J for exceptions.

WHAT IF MEDICARE CONSIDERS A SERVICE TO BE UNNECESSARY?

If physicians recommend a procedure that they are (or should be) aware is not covered by Medicare, they are required to notify you in writing that Medicare will not cover the service. Similarly, if a surgeon does not accept assignment for elective surgery, the physician must give you a written estimate if the charge will exceed $500.

WHAT IS ASSIGNMENT?

It is acceptance of the charges allowed by Medicare as payment in full.

WHAT IS A LIMITING CHARGE?

Physicians who do not accept assignment are limited to charging 115 percent of the fee schedule for nonparticipating doctors.

WHAT IS ISSUE AGE?

The premium is established when you buy your policy. You continue to pay the premium required of a person who is the same age you were when you bought your policy. For example, if you buy a policy at age 65, you always will pay the rate that the company charges people who are 65, regardless of your age.

IF I ALREADY HAVE A MEDICARE SUPPLEMENT, SHOULD I REPLACE IT WITH A STANDARDIZED PLAN?

New is not necessarily better. Some of the Medicare supplements sold prior to a 1990 federal standardization have more comprehensive benefits than the 12 new standardized plans. Carefully review your coverage before you replace your policy. It may be to your advantage to keep the old policy. Be aware, however, that these prestandardized plans may cost more as the insured population becomes older and in need of more health care insurance.

HOW DO I KNOW HOW MUCH COVERAGE TO BUY?

It is important to know how to assess your need for insurance in every type of coverage you buy. With a Medicare supplement policy, you should review your medical care costs for the preceding year, assess your current health status and choose a plan that is affordable. You may want to consider a policy with prescription coverage if you currently are taking medications. The cost of prescription drugs has increased dramatically in the last few years.

WHAT IS ATTAINED AGE?

The premium is based on your current age and increases automatically as you grow older. Typically, these plans are less expensive for younger individuals, but may cost considerably more in later years.

CURRENT BENEFITS FOR SENIOR CITIZENS

The Qualified Medicare Beneficiary Program and Spousal Impoverishment Program are available to assist seniors. These are important benefits if you have limited income and assets or if your spouse is in a long-term care facility.

The Qualified Medicare Beneficiary Program is designed to provide Medicare premiums, deductibles and coinsurance for seniors with limited incomes. The federal government sets the income level for individuals and couples each year. To find out if your income qualifies, contact the Human Resources office in your county. This program will not pay for expenses that Medicare does not allow.

You may suspend your Medicare supplement policy upon enrollement in the Qualified Medicare Beneficiary Program. You will need to notify your insurance company in writing of your eligibility within 90 days. If you lose your eligibility for the beneficiary program, you may reinstitute your Medicare supplement policy by notifying the insurer in writing and paying the premium within 90 days of the termination of your eligibility.

The Specified Low Income Beneficiaries Program assists individuals with slightly more income than those who are Qualified Medicare Beneficiaries by paying their Part B premiums each month. Individuals and couples with monthly income in a range specified by the federal government qualify. In addition to the income limit, financial resources including bank accounts, stocks and bonds cannot exceed $4,000 for an individual or $6,000 per couple.

Under the Spousal Impoverished Program, when a spouse enters a long-term care facility, there are rules for the division of the couple's assets. The spouse at home may retain a maximum of half the couple's resources, not to exceed a maximum set by the federal government. Certain assets are exempt, including the home, household goods and one car. There are regulations concerning the amount of income the spouse at home may retain on a monthly basis. Either spouse may request an assessment of resources when one spouse enters a nursing home. You will need to contact your county welfare office for more information or the state Aging Services Bureau at (406) 444-7788.

OTHER COVERAGES

Medicare provides partial coverage of mammograms. Seniors may have an annual mammogram for screening purposes. They must be performed by a certified facility and other restrictions may apply. Please see the chart on page 8 for additional coverages.

MEDICARE SUPPLEMENT STANDARDIZATION

The Omnibus Budget Reconciliation Act of 1990 (OBRA) included new standards for Medicare supplement insurance. As a result of this federal legislation, there are only 12 Medicare supplement policies available. They should facilitate the exact comparison of coverage and premiums. The standardized policies are described on page 10. Company information in the cost comparison insert will list the premium for each plan offered.

If you already have a Medicare supplement, you **do not need to replace it with a standardized policy.** Your old policy may have more benefits than a standardized policy. Review your coverage carefully before you replace your policy.

OPEN ENROLLMENT

OBRA requires insurance companies that sell Medicare supplement insurance to issue policies to seniors who qualify for Medicare Part B because they have reached age 65, without regard to their current health status. This open enrollment period lasts six months beginning with eligibility for Part B of Medicare.

Companies may not refuse to issue a Medicare supplement to you or delay the issue of the policy based on your medical condition, health status, claims experience or receipt of health care. The company may impose a six-month pre-existing condition clause during the first six months of the policy.

If you delay enrollment in Part B of Medicare and are covered by a plan provided by your or your spouse's employer, you will have an open enrollment period starting with the month in which you no longer are covered by the employer's plan. Your open enrollment period will start when your Part B coverage becomes effective.

If you miss your open enrollment period, contact your local Social Security Office. There may be a waiting period for coverage and premium payments due. Some individuals are eligible for Medicare due to a disability and are under age 65. The open enrollment period applies to these individuals upon turning 65.

PART B CHARGES

Health care providers are required to bill Medicare directly for beneficiaries. Amounts billed on Part B of Medicare may not exceed 115 percent of the Medicare allowable amount for 1993. The law requires physicians to refund charges over the 115 percent within 30 days.

MEDICARE COVERAGES

Medicare Hospital Insurance = Medicare Part A

Medicare pays for all but $792 of your hospital stay during each benefit period for reasonable and necessary care in the first 60 days of confinement. For the next 30 days, it pays all but $198 a day for covered services. Medicare pays expenses in excess of $396 a day during the 91st through 150th days. These are Lifetime Renewable Days and may be used only once. If you are hospitalized for more than 150 days, Medicare pays nothing.

A benefit period begins the first day of hospitalization and ends when you have been out of a hospital or skilled nursing facility for 60 consecutive days. It is possible to have more than one benefit period and more than one hospital deductible in a calendar year.

Charges for skilled nursing facility stays may be paid by Medicare if the facility is a Medicare-certified facility. To qualify for this benefit, you must have been hospitalized for at least three days and have been admitted to the nursing facility within 30 days of discharge from the hospital. The first 20 days are covered at 100 percent provided you are receiving skilled care. The next 80 days Medicare pays amounts more than $99 a day. Beyond the 100th day, Medicare pays nothing.

Under certain conditions, home health care is available for homebound beneficiaries. This coverage includes skilled nursing services, occupational therapy, and physical and speech therapy if provided by a Medicare-certified home health service and if determined to be medically necessary. If your physician establishes a care program that requires durable medical equipment, Medicare will pay 80 percent of the Medicare-approved cost of the equipment. Call 1-800-899-7095 for more information.

Medicare provides coverage for hospice care for patients certified as terminally ill. This benefit is divided into two 90-day hospice benefit periods and one 30-day benefit period. A subsequent extension also may be covered.

You pay for the first three pints of blood and Medicare pays for any additional blood.

Medicare Medical Insurance = Medicare Part B

Medicare covers physician services, outpatient hospital services, lab services, X-ray, radiation and therapy services, home health visits, physical therapy, speech pathology services, some forms of vaccinations, durable medical equipment, limited ambulance services, prosthetic devices, immunosuppressive drugs for the first year following an organ transplant, and other medical supplies and equipment. In 2001, the Part B premium is $50 a month. You are not required to purchase Part B, but is an excellent buy because the federal government pays most of the actual cost.

The Part B deductible is the first $100 of expenses in a calendar year. After the deductible, Medicare pays 80 percent of the approved charges.

The Medicare deductible for blood expense is the cost of the first three pints.

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES PER BENEFIT PERIOD FOR 2001

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
HOSPITALIZATION Semi-private room and board, general nursing, and miscellaneous hospital services and supplies.	First 60 days 61st - 90th day 91st - 150th day* Beyond 150 days	All but $792 All but $198 a day All but $396 a day Nothing	$792 $198 a day $396 a day All costs
POST-HOSPITAL SKILLED NURSING FACILITY CARE You must have been in a hospital for at least three days and enter a Medicare-approved facility, generally within 30 days of hospital discharge.	First 20 days The next 80 days Beyond 100 days	100 % of approved amount All but $99 a day Nothing	Nothing $99 a day All costs
HOME HEALTH CARE	Medically necessary skilled care, home health aide services, medical supplies, etc.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Available to terminally ill.	If a doctor certifies the need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited during a benefit period if medically necessary.	All but the 1st three pints in a calendar year.	The 1st three pints in a calendar year.

*Lifetime Reserve Days may be used only once.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR 2001 (Premium $50)

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
MEDICAL EXPENSE Physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible and 20% of the approved amount (plus any charge above the approved amount).
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	Full cost of services.	Nothing for services.
HOME HEALTH CARE	Medically necessary skilled care, home health aide services, medical supplies, etc.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80% of approved amount (after $100 deductible).	$100 deductible plus 20% of approved amount.
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with the fourth pint).	First three pints plus 20% of approved amount for additional pints (after $100 deductible).*

*To the extent that the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

Prevention Benefits

	2000	2001	2002	2003
Mammograms	Covered Annually	⇨	⇨	⇨
Pap Smears	Covered Every Three Years*	⇨	⇨	⇨
Prostate Cancer Screening	Covered Annually	⇨	⇨	⇨
Colorectal Cancer Screening	Covered Annually	⇨	⇨	⇨
Diabetes Self-Management	Covered Annually	⇨	⇨	⇨
***Covered annually for high-risk women.**				

Future Medicare Options

	1997	1998	1999	2000	2001	2002	2003
Options	Choice of traditional Medicare and HMOs.*	Choice of traditional Medicare, managed care plans and private fee-for-service.*	Choice of medical savings accounts (MSAs) option added. (Experimental program limited to 390,000 enrollees.*)	⇨	⇨	⇨	⇨
Enrollment	Option to change plans on a monthly basis.	Option to change plans on a monthly basis.	Option to change plans on a monthly basis.	⇨	⇨	One six-month period each year in which to change plans.	One three-month period each year in which to change plans.

TRADITIONAL MEDICARE - You visit any doctor that takes Medicare. You also may buy a supplemental policy to pay for services and costs allowed but not paid by Medicare.

MANAGED CARE PLANS - Includes a range of plans such as Health Maintenance Organizations (HMOs), Point-of-Service (POS), Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs) that limit the list of doctors you can see, but often offer extra benefits.

PRIVATE FEE-FOR-SERVICE - You can visit any doctor or purchase any health plan but you pay extra for uncovered or expensive services.

MEDICAL SAVINGS ACCOUNT (MSA) - Medicare would provide you with a high deductible catastrophic insurance policy and advance you a portion of the high deductible. At the end of the year, you may keep any unused Medicare money.

***These plans may not be available in Montana.**

10 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

CORE BENEFITS	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan F*	Plan G	Plan H	Plan I	Plan J	Plan J*
Part A Hospital (Days 61-90)	X	X	X	X	X	X	X	X	X	X	X	X
Lifetime Reserve (Days 91-150)	X	X	X	X	X	X	X	X	X	X	X	X
365 Life Hospital Days - 100%	X	X	X	X	X	X	X	X	X	X	X	X
Parts A and B Blood	X	X	X	X	X	X	X	X	X	X	X	X
Part B Coinsurance - 20%	X	X	X	X	X	X	X	X	X	X	X	X
ADDITIONAL BENEFITS	**A**	**B**	**C**	**D**	**E**	**F**	**F***	**G**	**H**	**I**	**J**	**J***
Skilled Nursing Facility Coinsurance (Days 21-100)			X	X	X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X	X	X
Part B Deductible			X			X	X				X	X
Part B Excess Charges						100%	100%	80%		100%	100%	100%
Foreign Travel Emergency			X	X	X	X	X	X	X	X	X	X
At-Home Recovery				X				X		X	X	X
Prescription Drugs									1	1	2	2
Preventive Care					X						X	X

Core benefits pay the patient's share of Medicare's approved amount for physician services 20% after a $100 annual deductible, the patient's cost of a long hospital stay ($184/ day for days 60-90, $384 for days 91-150, all approved costs not paid by Medicare after day 150 to a total of 365 days lifetime) and charges for the first three pints of blood not covered by Medicare.

Two prescription drug benefits are offered:

1. A basic benefit with a $250 annual deductible, 50 percent coinsurance and a $1,250 maximum annual benefit (Plans H and I).

2. An extended benefit containing a $250 annual deductible, 50 percent coinsurance and a $3,000 maximum annual benefit (Plan J).

***Plans F and J have options called high deductibles, which pay the same or offer the same benefits as Plans F and J after the insured has paid a calendar year ($1,580) deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses reach $1,580. Out-of-pocket expenses for this deductible are expenses that ordinarily would be paid by the policy. These expenses include the Medicare deductibles for Parts A and B, but do not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the separate foreign travel emergency deductible.**

Important Telephone Numbers

Durable Medical Equipment: 1-800-899-7095

Home Health Care Offices: (515) 245-4834

Medicaid: 1-800-624-3958 or (406) 442-1837

State Health Insurance Assitance Program:
1-800-332-2272

Medicare eligibility, a new Medicare card or information on how to apply for Medicare coverage: Call the local Social Security Office listed below or the toll-free number: 1-800-772-1213

Billings	1-800-543-0524	Havre	265-5472
Bozeman	586-4501	Helena	441-1270
Butte	723-8246	Kalispell	755-1015
Glasgow	228-8272	Missoula	251-1580
Great Falls	761-5703	Premium problems	1-800-833-6364

Medicare Part A: For questions regarding hospital claims, 1-800-447-7828

Medicare Part B: For questions regarding physician claims, 1-800-332-6146 or (406) 444-8350

Montana Insurance Commissioner: For questions about insurance, 1-800-332-6148

MONTSHARE is a program that is designed to improve access to medical care for seniors experiencing financial difficulties. This program was initiated by local physicians, hospitals and the Montana Medical Association. Under MONTSHARE, physicians are asked to accept Medicare assignment. 1-800-662-9287

Peer Review Organization (PRO): If you think you have a problem with quality of care from a physician or supplier, call 1-800-497-8232 or (406) 443-4020.

Qualified Medical Beneficiary (QMB): (406) 444-4540

Supplemental Insurance questions for federal employees, 1-800-634-3569 or (406) 791-1400

Travelers Medicare: (Railroad Retirement) Your Medicare number will have an alpha character before your Social Security number. 1-800-833-4455

United Mine Workers: 1-800-843-8109

We have compiled a list of insurance companies that offer policies to people who are less than 65 years old and are on Medicare by reason of disability. The Montana Comprehensive Health Association also offers a Medicare Supplement policy to individuals who cannot get insurance coverage. The individual must have been turned down by two companies before becoming eligible for MCHA coverage. **Please consult our price comparison list for full information.**

BUYERS' CHECKLIST

The majority of insurance companies and agents are highly ethical, however, a few are not. Not all of the following activities are illegal or unethical, but if after reviewing this checklist, you think an agent has acted improperly, please contact the following:

MONTANA INSURANCE DEPARTMENT
Policyholder Services Bureau
P.O. Box 4009
Helena, MT 59604

Phone: (406) 444-2040
Toll-Free Number: 1-800-332-6148

1. Did the agent try too hard to convince you of the possibility of you becoming bankrupt, of your plans for retirement being disrupted, or of your savings and that of your children or relative being wiped out because of extended illness?
2. Did the agent lead you to believe he or she was a representative of the Medicare program, Insurance Department or other government agency?
3. Did the agent suggest you drop a policy you already have in order to buy the policy he or she was selling?
4. If you already have purchased a policy from an agent, has that agent changed companies and suggested you change your policies over to one offered by the agent's new company?
5. Did the agent suggest you falsify any information on the policy?
6. Did the agent discourage you from shopping around or checking out the policy thoroughly before deciding whether to buy it? Did he or she make you feel like you had to sign up the same day?
7. Did the agent ask you to pay in cash or make your check out to him or her personally or to the agency, instead of the company?
8. Did the agent fail to explain the policy to you or answer your questions completely?
9. Did the agent complete your health history information on the application exactly as you explained it before you signed the application?

SHOPPING TIPS

Changes in federal law make it easy to shop for Medicare supplement insurance coverage. Before you start comparing policies, consider these five suggestions:

1. Learn about Medicare's basic coverage and gaps.

2. Study the 12 standard Medicare supplement insurance plans. Decide what coverage would best meet your health needs and financial circumstances.

3. Compare only the policies that meet your needs. Although the benefits are identical for all Medicare supplement insurance plans of the same type, premiums vary widely among companies and so does the potential for premium increases.

4. Consider your alternatives. If you have limited income and assets, you may qualify for free coverage through other government programs.

5. Contact the state health insurance counseling program for an impartial, free review of your existing coverage. In Montana, the number is 1-800-332-2272.

DON'T BE A VICTIM OF INSURANCE FRAUD

Common Schemes

- Overcharging for premiums.
- Collecting annual premiums but submitting only quarterly payments to insurance companies.
- Collecting large, lump-sum premiums from seniors and retaining portions of it, hoping that the seniors die before the misappropriations are noticed by family.
- Not returning refunds from companies to the insured person.

To Avoid Becoming a Victim

- Insist on timely delivery of documents.
- Call the company yourself to confirm coverage.
- Read the documents you receive and ask questions. Make agents and companies reply to inquiries in writing.
- Don't buy unless you understand the policy.
- Get to know the agent. Be skeptical of the door-to-door approach.
- Ask for and use direct billing for premium payments. Don't forward payment to companies through agents if you can avoid it.

DEFINITIONS

In order to make a wise purchase, it is important to become familiar with the terms used by Medicare and Medicare supplement policies. You may wish to familiarize yourself with the following terms:

ASSIGNMENT: The transfer by the policyholder of some or all of his or her rights under a policy to another party. If assignment is noted on the claim form, the insurance company will pay the health care provider directly. Medicare assignment means the provider will accept the Medicare-approved amounts for covered services as payment in full. The beneficiary would then be responsible for any unmet deductible applied to the charge, for the co-insurance and for any services that were not approved.

COPAYMENT: Your portion or percentage of a health expense. For example, the insurance would pay 80 cents of every dollar on the provider's charges. You pay the remaining 20 cents. With Medicare, the coinsurance would be based on Medicare-allowable charges.

CONDITIONALLY RENEWABLE: The insurance company will continue insuring you so long as you pay the premium and continue to meet the terms stated in the policy.

DEDUCTIBLE: The amount of covered expenses you must pay before benefits become payable by the insurers.

EXCLUSIONS OR LIMITATIONS: Specified conditions, circumstances or services not covered by the policy.

GUARANTEED RENEWABLE: The insurance company agrees to continue insuring you so long as you pay the premium. The company reserves the right to nonrenew all contracts in the state.

MEDICARE-ALLOWABLE CHARGES: The amount deemed reasonable by Medicare for a given medical service. Benefits are based on Medicare-allowable charges, which may be less than the provider's charges.

PRE-EXISTING CONDITIONS: A physical condition that existed before the policy became effective. Montana law does not allow Medicare supplement policies to exclude coverage for more than six months after the effective date of the policy on the grounds that a condition existed prior to the effective date of coverage. Companies that replace a Medicare supplement policy must waive the pre-existing waiting period on the replacement policy. If the insured has not completed the waiting period on the first policy, any period of time that was completed must be credited on the new policy. This does not apply to those who previously have not purchased a Medicare supplement policy or to those who have not had a policy within the last 31 days.

The State Auditor's Office attempts to provide reasonable accommodation for any known disability that may interfere with a person's ability to participate in any service, program or activity of the agency. Alternative accessible formats of this document will be provided upon request. For more information call (406) 444-2040 or TDD (406) 444-3246.

INS. 1301-93

JOHN MORRISON
STATE AUDITOR AND INSURANCE COMMISSIONER
P.O. BOX 4009
HELENA, MONTANA 59604-4009
TELEPHONE (406) 444-2040 / MONTANA TOLL FREE 1-800-332-6148

INSURANCE INQUIRY/COMPLAINT FORM

In response to your recent request for assistance, we are sending our Insurance Report Form. Please complete this form and mail to: JOHN MORRISON, STATE AUDITOR AND INSURANCE COMMISSIONER, P.O. Box 4009, Helena, Montana 59604-4009. It often takes several weeks for the Department to complete the review and take appropriate action. You will hear from a Compliance Specialist in writing as soon as the review is complete.

Your Name Phone No. _____

Address _____
(City) (State) (Zip Code)

Date of Birth _____

Social Security Number _____

Insurance Company's Name _____

Policy No. Claim No. _____

Kind of Policy: _ Auto _ Life _ Health _ Property _ Other

Agent's name Date of Loss _____

Please indicate which of the following is applicable:

My complaint is against: _ COMPANY _ AGENT _ ADJUSTER

1. ___ The company has unfairly rejected my claim or has not paid the full benefits to which I am entitled.
2. The company has delayed processing my claim and I am unable to obtain a response from them.
3. The company has not refunded premium moneys that are due me.
4. I believe the company's action of cancellation or non-renewal of my policy is not justified.
5. Other _____

Do you have an attorney handling this for you? If not, in your own words, describe your problem. If more space is needed, please add additional sheets. Enclose copies of papers and other correspondence relative to this problem. A copy of this form may be forwarded to the insurance company involved.

_____

_____

_____

Signature Date _____

Use Reverse for Additional Comments

This publication has been created or produced by Montana with financial assistance, in whole or in part, through a grant from the Health Care Financing Administration, the federal Medicare agency.